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Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

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Office of the Exchange
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
Bethesda, MD
FFEcomments@cms.hhs.gov

To Whom It May Concern:

The Association for Community Affiliated Plans (ACAP) very much appreciates this opportunity to comment on CCIIO's *General Guidance on Federally-Facilitated Exchanges*, published May 16, 2012, and to continue the discussion ACAP has had with CCIIO regarding the federally-facilitated Exchange (FFE). We appreciated the opportunity to meet with CCIIO staff in May. Our members have developed the following positions on the bulletin.

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 26 states.[1] Our member plans provide coverage to approximately 9 million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Nationally, ACAP plans serve approximately one-third of all Medicaid managed care enrollees. Safety Net Health Plans currently are developing plans to serve those individuals that will gain new coverage due to insurance expansions enacted by the Affordable Care Act, including the Exchanges.

ACAP thanks HHS for its proposal to take an inclusive approach to certifying qualified health plans for the FFE. As you continue to develop regulations related to the FFE, we respectfully urge you to consider the following recommendations that will help remove barriers to participation in the FFE by SNHPs, thereby helping to ensure low-income health care consumers are well-served by the Exchanges and qualified health plans.

Several of our comments relate specifically to the bulletin, but we have included additional issues that may be more closely related to other guidance. A summary of our comments follows here:

- ACAP urges the FFE to aggregate premiums.
- ACAP requests HHS to support a change to the HRSA loan guarantee program for SNHPs, and requests the FFE to implement a 5-year grace period for reserves for SNHPs using the definition of these plans in section 9010(c)(2) of the Affordable Care Act.
- ACAP urges the FFE to adhere to a series of recommendations related to agents and

[1] ACAP represents safety net health plans that are exempt from federal income tax, or that are owned by an entity or entities exempt from federal income tax, and in which no less than 75 percent of the enrolled population receives benefits under a Federal health care program as defined in section 1128B(f)(1) (42 USC 1320a-7b(f)(1)) or a health care plan or program which is funded, in whole or in part, by a State or locality (other than a program for government employees).

brokers.

- Regarding certification of qualified health plans for the FFE, ACAP requests that the FFE employ the "bridge proposal" for Medicaid MCOs, allow Medicaid MCOs a grace period to attain licensure, and avoid requiring all Medicaid MCOs serve the FFE.
- ACAP requests that the FFE provide a transitional period until 2017 for all health plans that are not currently accredited to obtain the required accreditation for plan participation.
- ACAP strongly encourages HHS to affirm its commitment to seamless, fully-integrated eligibility systems that provide all health care consumers approaching the FFE with "no wrong door" eligibility and enrollment services. ACAP also recommends that should the FFE employ a bifurcated "screen and refer" eligibility policy, it should publicly demonstrate the ability to manage such a situation effectively.
- ACAP requests HHS to allow employee choice in the FF-SHOP.
- ACAP supports HHS creating an advisory board in states with an FFE.
- ACAP asks HHS to use the FFE webpage to "draw a bright line" around Medicaid MCOs.
- ACAP asks HHS to permit states with an FFE to operate a BHP.

Our full comments follow.

1. **ACAP urges HHS to allow the FFE to aggregate premiums.**

   Section 1312(b) of the Affordable Care Act indicates that any qualified individual may pay premiums directly to qualified health plan issuers. The preamble to the draft Exchange Establishment rule noted that an Exchange could act as a simple pass-through for premiums or could collect and distribute premiums to QHP issuers. The final Exchange Establishment rule stated that "premium aggregation has potential benefits for individuals," and that "Exchanges have the flexibility to create a default payment mechanism through the Exchange, and to direct individuals to select a payment option for a year at the time of enrollment."

   We support aggregation of premiums by the FFE for several reasons. First, we believe that allowing enrollees to pay premiums to the Exchange will reduce confusion among the covered population. The final Exchange rule includes a special enrollment period that will allow individuals to switch health plans mid-coverage year. Should people take advantage of this enrollment period, premium aggregation by the FFE allows them to maintain a steady contact for financial transactions related to their coverage. Further, it is anticipated that lower-income individuals who will receive premium tax credits will experience significant income volatility throughout the year. As incomes change, so do individual premium contributions and premium tax credit amounts. Allowing enrollees to pay a single entity that will also have access to the federal data "hub" with information on eligibility for premium tax credits will only increase trust in the Exchange and the easy flow of information to the enrollee.

   We also believe that certain premium payment practices could serve as a barrier to participation in the FFE by SNHPs. Allowing enrollees to select from among a multitude of premium payment options could cause each qualified health plan to have an enrolled population without a standardized method of premium payment. The added complexity of

such a system may discourage participation among some plans – such as Medicaid plans – that are building commercial functions such as a premium collection apparatus for the first time.

In addition, the FF-SHOP will aggregate premiums for employers purchasing small group coverage. This is a function that HHS must develop and implement for the FF-SHOP; we believe that it could be employed for the FFE as well.

ACAP strongly urges the FFE to aggregate premiums centrally.

2. **ACAP requests HHS to support a change to the HRSA loan guarantee program for SNHPs, and requests the FFE to implement a 5-year grace period for reserves for Medicaid plans**.

   ACAP members have identified reserve requirements as a significant impediment for SNHPs not just for the Exchange, but also for the other coverage expansions they intend to support, including the Medicaid expansion to people with incomes up to 133 percent of the FPL and expansions to dually-eligible individuals. Unlike for profit plans, SNHPs do not have the opportunity to raise capital. However, it is critically important that Safety Net Plans have an opportunity to serve Exchange enrollees who are low-income and otherwise vulnerable, as these individuals are dissimilar to the existing commercial population and will require special services and expertise that Safety Net Health Plans have developed during years of supporting Medicaid programs.

   ACAP is undertaking a variety of activities to assist plans to address the reserve issues which are potential barriers to expansion in the Medicaid (for both expansion and dual eligible populations) and Exchange programs. In addition to noting that support for additional exclusions from the excise tax will assist SNHPs to grow their reserves, ACAP has discussed this issue in numerous venues, and has had preliminary conversations with CMS and HRSA staff about the possibility of expanding the HRSA Loan Guarantee program to address SNHP needs. Expansions could take the form of either increasing the funding under the current program (which would only assist CHC-affiliated plans) or promoting a look-alike program for SNHPs. We are also gathering additional data in the expectation that it will support expansion of these programs by demonstrating that ACAP plans have lower reserve levels than other health plans.

   ACAP is currently developing our work plan for modifying the loan guarantee program, and will provide more information to CCIIO as the work plan progresses.

   In addition, ACAP previously requested that HHS allow states to implement a five-year transitional period (until 2019) for Safety Net Health Plans to build required reserves to serve the Exchange. We also requested that HHS implement this strategy for the FFE. For this policy, HHS should employ the definition of Safety Net Health Plans and government plans appearing in the Affordable Care Act at section 9010(c)(2). The section provides an exemption from the health insurer fee for health plans that are nonprofit and derive 80

percent of revenues from Medicare, Medicaid and CHIP. (This section also exemps government plans.) During the transition period, Safety Net Health Plans would be required to meet benchmark solvency requirements.

There is precedent for a phase-in of solvency requirements. The State of New York currently is in the process of phasing in increasingly stringent solvency requirements for certain health plans serving the New York Medicaid program.

> **Exchange guidance should indicate that states must implement a five-year transitional period (until 2019) for Safety Net Health Plans to build required reserves.**

3. **ACAP urges the FFE to adhere to a series of recommendations related to agents and brokers.**

ACAP has previously submitted these recommendations to HHS in our comments to the draft Exchange Establishment rule. Although ACAP recognizes the value of brokers and agents to health coverage, and is aware that policies impacting the use of brokers and agents differ from state to state and market to market, ACAP Safety Net Health Plans anticipate serving a lower-income and higher-needs population in the Exchange to expand upon their missions of working with low-income enrollees of Medicaid and CHIP. These plans expect to benefit from the community-based education and outreach activities provided by community-based organizations, including those serving the Navigator program. Some ACAP plans intend to use the services of brokers and agents when the Exchanges are operational, although it is uncertain whether all will.

Therefore, we respectfully request that the FFE:

- **Require that agents and brokers be paid the same** amounts inside and outside of Exchange and regardless of which plan a consumer chooses.
- **Require that payments to brokers and agents be transparent.** If information related to brokers and agents is included on an Exchange's website, the website should also display information on broker and agent fees.
- **Implement a system that pays brokers and agents a flat fee.** Although brokers and agents currently are paid a percentage of premiums, ACAP believes that incentives to steer patients to expensive plans will be mitigated if brokers and agents be paid a flat fee.
- **Provide qualified health plans with a choice** regarding:
  - Whether to use brokers and agents.
  - Which brokers and agents to use.
- **Require brokers and agents to charge qualified health plans directly *only* when a broker or agent sells that particular qualified health plan to a consumer.** If no broker or agent sells the qualified health plan (i.e., the plan is purchased directly by the consumer), the plan should not be charged.
- **Exclude broker and agent fees** from the FFE's overhead.

4. **Regarding certification of qualified health plans for the FFE, ACAP requests that the**

FFE employ the following policies:

a. **The "Bridge" proposal.** This policy would allow the FFE to certify as licensed those Medicaid and CHIP health plans with enrollees who move into the Exchange and which cover families with split eligibility for the purpose of continuing to cover those individuals and families only. Individuals and families could be offered an "opt-out" if they choose to select a different plan in the Exchange rather than remain with their Medicaid or CHIP plan. If the plan wishes to seek certification as a qualified health plan to serve "all-comers" in the Exchange, the plan can do so by meeting the requirements of that Exchange. We have heard from CCIIO leadership that federal guidance on this policy is imminent.

b. **A grace period for full licensure.** ACAP urges HHS to allow Medicaid health plans to be given a period of not fewer than two years to gain licensure, providing each state Department of Insurance with an opportunity to conduct audits for provisional licensure while the health plans undergo the licensing process.

c. **Flexibility for Medicaid health plans.** ACAP urges HHS to prohibit states from requiring all Medicaid health plans to serve the Exchange, and from requiring all Exchange plans to serve Medicaid. A report published in 2011 by the Kaiser Family Foundation titled *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey* (http://www.kff.org/medicaid/8220.cfm) indicates that eight states are considering requiring Medicaid plans to serve the Exchange. Because other barriers to serving the Exchange exist for Safety Net Health Plans, including reserves and accreditation rules, such a requirement could present some mission-based plans with an obligation they cannot fulfill. In 2014, these plans will also face an expansion of the Medicaid program to approximately 16 million new individuals nationally. Most Safety Net Health Plans currently serve only Medicaid and CHIP; if they are required to serve the Exchange to maintain a Medicaid presence but find they are unable to do so, these plans could be put out of business entirely, causing substantial disruption for Medicaid programs and enrollees. The Kaiser report also notes that seven states are considering requiring Exchange plans to serve Medicaid; this requirement could distort the Medicaid market by disadvantaging smaller, local, nonprofit and mission-oriented health plans, and may similarly cause disruption for Medicaid enrollees.

   While ACAP strives to ensure that Safety Net Health Plans are able to serve the Exchanges, we recommend against requiring that Medicaid health plans serve the Exchange, and qualified health plans serve Medicaid.

5. **ACAP requests that the FFE provide a transitional period until 2017 for all health plans that are not currently accredited to obtain the required accreditation for plan participation.**

The final Exchange Establishment rule codifies the statutory requirement that the Exchange must establish a uniform period following certification of a qualified health plan within

which the plan must become accredited, and provides that "a grace period may be necessary since ... accreditation process may take twelve to eighteen months to complete." The May 16 bulletin indicated that HHS will opt to take advantage of this grace period for the FFE as well: HHS will allow plans currently without accreditation to schedule a review with NCQA or URAC during the first year of Exchange operations and achieve accreditation on qualified health plan policies by the second year.

ACAP advocated for a three-year grace period – until 2017 – for Medicaid plans to gain accreditation in our October 31, 2011 letter to HHS responding to the draft Exchange Establishment rule. We very much appreciate that HHS chooses to employ a grace period. However, for two reasons in particular, we urge HHS to extend the timeframe for accreditation for all qualified health plans.

First, accreditation is an intensive and time-consuming activity. Despite the grace period described in the May 16 bulletin, aspiring qualified health plans would have to commit to accreditation in the very near future to be accredited by 2015. Because of continued uncertainty regarding which states will employ an FFE and how the FFE will operate, this will be difficult for many unaccredited Medicaid plans.

Second, as mentioned previously, HHS proposed in June 5 guidance that NCQA and URAC be recognized as accrediting entities for the first phase of the Exchanges. ACAP supports HHS allowing more than one entity to accredit qualified health plans, and included a request in our October 31 letter that HHS avoid requiring all plans to obtain necessary accreditation from one particular entity. Still, two accrediting entities alone may be overwhelmed by the number of new requests for accreditation, which may make the 2015 deadline difficult to meet.

> **ACAP respectfully repeats its request to HHS to have the FFE provide a three-year grace period – until 2017 – for Medicaid health plans to achieve accreditation.**

- **Regarding eligibility determinations for Medicaid, CHIP, Basic Health Program (BHP) and the Exchange, ACAP strongly encourages HHS to affirm its commitment to seamless, fully-integrated eligibility systems that provide all health care consumers approaching the FFE with "no wrong door" eligibility and enrollment services.** Furthermore, in the event that HHS decides to retain the bifurcated eligibility process for the FFE currently outlined in the Exchange Establishment interim final regulation, **ACAP recommends that the FFE publicly demonstrate the ability to manage such a situation effectively**.

ACAP has written to HHS regarding eligibility and enrollment policy twice, first in response to the Exchange Eligibility draft regulation on October 31, 2011, and then in response to the Exchange Establishment interim final rule on May 11, 2012. In both cases, we articulated our strong support for a fully-integrated, seamless, "no wrong door" approach to eligibility and enrollment for all applicants, regardless of whether they approach the Exchange, a Medicaid agency, the CHIP program or a Basic Health Program.

In our response to the interim final rule last month, we made the following requests. We stand by these requests and urge the FFE to adopt these approaches:

> By allowing the Exchange to "screen and refer," the interim final rule raises concerns that the concept of "no wrong door" for applying for health insurance coverage will be substantially diminished. "Screen and refer" unnecessarily bifurcates the eligibility process and increases the chance that individuals will be lost in the process and experience gaps in coverage. Moreover, with the possibility that applicants may receive communications from organizations to which they did not apply, we are concerned that they may not recognize the nature of the communication and will fail to respond as necessary to complete the application process. Overall, establishing such a process will damage the ability of the Affordable Care Act to realize its promise of health care coverage.
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> > **ACAP strongly encourages the FFE to reaffirm its commitment to seamless, fully-integrated eligibility systems that provide all health care consumers with "no wrong door" eligibility and enrollment services.**
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> As we describe in our letter response to the interim final regarding *Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010*, we believe that CMS should require states to demonstrate that their Medicaid agencies either have the capacity to conduct eligibility determinations in compliance with the final Medicaid eligibility rule or are moving in that direction and will be able to meet this requirement by the end of the interim time period. Moreover, states should be required to demonstrate that they are able to process eligibility determinations without any re-verification of existing data. Similarly, to minimize the possibility that the Exchange and the state agency will arrive at differing eligibility determinations and/or that the state will re-do the eligibility assessment using different standards, the Exchange should be required to use the same rules engine definitions and criteria as the state does.
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> Our requests stand also for the FFE.
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> > **In the event that HHS retains the bifurcated eligibility process currently outlined in the interim final regulation, ACAP recommends that the FFE publicly demonstrate the ability to manage such a situation effectively**.

We also request that in future guidance regarding the FFE, HHS describe the integrated eligibility and enrollment system as including determinations and enrollments for the Basic Health Program as well as for the FFE, Medicaid and CHIP.

6. **ACAP requests HHS to allow proposal to allow employee choice in the FF-SHOP.**

ACAP believes that allowing employees a choice of health plans within the metal level selected by their employer in the SHOP exchange is fair policy. Employee choice of plans increases the portability of insurance and allows for continuity across families in cases where the FFE includes qualified health plans that are also Medicaid and CHIP plans.

We suggest that the alternative – employers limiting plan choices for employees – potentially creates a barrier to cohesive, family coverage for those families with members eligible for different programs, unless the FF-SHOP requires at least the choice of a Safety Net Health Plan. Also, because agents and brokers will continue to "sell" the qualified health plans from issuers with whom they have a strong relationship, restricting employee choice may create a barrier for entry for Safety Net Health Plans that do not currently enjoy strong broker relationships because of their traditional role in the public coverage market, which does not frequently employ brokers.

7. **ACAP supports HHS creating an advisory board in states with an FFE.**

On page 18 of the bulletin, HHS indicates that it intends to work closely with local stakeholders to implement each FFE, and that it is exploring with the National Association of Insurance Commissioners (NAIC) whether an advisory board should be created in states that do not have them already. HHS sought input on opportunities for HHS to work with local stakeholders to develop a successful FFE.

Because the insurance marketplace is inherently local, we feel as though state input is critical to the success of any FFE. We strongly support inclusion by representatives of the safety net on these boards. Furthermore, the diversity of the insurance issuer universe is such that full representation by insurers cannot be achieved unless plans who serve low-income and high needs individuals are included; we urge HHS specifically to look to SNHPs to round out the health plan perspective on any advisory board it establishes.

> **ACAP supports creation of a formal advisory board in FFE states, and in particular requests that HHS include representation by Safety Net Health Plans on these boards.**

8. **ACAP asks HHS to use the FFE webpage to "draw a bright line" around Medicaid MCOs.**

To best serve individuals whose eligibility changes frequently as well as families whose eligibility is split between programs, we request that the FFE website indicate clearly which qualified health plans also operate Medicaid and CHIP MCOs. This could serve as an educational tool for people regarding their new coverage, and could prevent the enrollment fatigue that could result from frequent eligibility and plan changes within a coverage year.

> **The FFE website should clearly indicate to consumers which qualified health plans also offer Medicaid and CHIP MCOs.**

9. **ACAP asks HHS to permit states with an FFE to operate a BHP.**

   ACAP believes that if an FFE operates within a state, the state should retain the option to establish a BHP. While the Exchange and BHP programs are tied together by their funding sources, we recommend that CMS treat these as distinct decisions by state officials and work with any state interested in implementing the BHP.

   States with an FFE should be allowed to operate a BHP.

We appreciate your consideration of our comments regarding. ACAP is prepared to assist the agency with additional information as needed. If you have any additional questions please do not hesitate to contact Jennifer Babcock at (202) 204-7518 or jbabcock@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer